BIRTH CERTIFICATE INFORMATION – MEDICAL PORTION

The information provided on this worksheet will be used to create the birth record.
Please complete this information carefully and completely.

Child's Medical Information

BIRTH ATTENDANT	MOTHER'S NAME OR MED RECORD NO.	DATE OF BIRTH

INFANT TRANSFERRED? ☐ Yes ☐ No If so, WHERE?	BABY'S MEDICAL RECORD NUMBER

BIRTH WEIGHT ☐ lb./oz. ☐ grams	ESTIMATED GESTATION In completed weeks	APGAR Scores
PLURALITY / # live born in this birth / birth order of this baby		1 min_____/ 5 min /10 min

MOTHER'S HEP B STATUS ☐ Negative ☐ Positive ☐ Unknown	Did baby get Hep B vaccine? ☐ No ☐ Refused If Yes - when?	HBIG given to baby? ☐ No ☐ Refused If Yes - when?

Abnormal conditions of the newborn

- ☐ Assisted ventilation immediately after birth
- ☐ Assisted ventilation > 6 hours
- ☐ NICU admission
- ☐ Newborn surfactant therapy
- ☐ Antibiotics for suspected sepsis
- ☐ Confirmed bacterial infection
- ☐ Seizure or neurologic dysfunction
- ☐ Birth injury
- ☐ Anemia
- ☐ Other _____
- ☐ None

Congenital anomalies

- ☐ Anencephaly
- ☐ Meningomyelocele /Spina bifida
- ☐ Hypospadias
- ☐ Other urogenital anomalies
- ☐ Cyanotic congenital heart disease
- ☐ Congenital diaphragmatic hernia
- ☐ Omphalocele
- ☐ Gastroschisis
- ☐ Limb reduction defect
- ☐ Polydactyly /syndactyly /adactyly
- ☐ Club foot
- ☐ Other musculoskeletal/integumental
- ☐ Cleft lip
- ☐ Cleft palate
- ☐ Down syndrome – confirmed? _____
- ☐ Other chromosomal – confirmed? _____
- ☐ Other anomalies _____
- ☐ None

WAS BABY BREASTFED or fed breast milk ☐ No ☐ During stay ☐ At discharge	INFANT ALIVE AT TIME OF FILING? ☐ Yes ☐ No	TIME OF BIRTH ☐AM ☐PM ☐24hr

BIRTH CERTIFICATE INFORMATION – MEDICAL PORTION

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Mother's Medical Information I - Prenatal

MOTHER'S NAME OR MED RECORD NO.		Did mother receive prenatal care? ☐ Yes ☐ No	
Date of first prenatal visit / /	Date of last prenatal visit / /	Total prenatal visits	Month of pregnancy care began (1st, 2nd, etc.)
Mother's height	Pre-pregnancy weight	Weight at delivery	Last menstrual period / /

Prev live births Still living	Prev. live births Now dead	Mo/Yr of last live birth /	Number of terminations or other outcomes	Mo/Yr of last other outcome /

Risk factors this pregnancy

- ☐ Diabetes – pre pregnancy
- ☐ Diabetes – gestational
- ☐ Hypertension – pre pregnancy
- ☐ Hypertension – gestational (PIH, preeclampsia)
- ☐ Eclampsia
- ☐ Pregnancy resulted from infertility treatments
  - ☐ Fertility drugs, artificial insem, intrauterine insemination
  - ☐ Assisted reproductive technology (IVF, GIFT)
- ☐ Anemia
- ☐ Previous preterm birth
- ☐ Other previous poor outcome (perinatal death, SGA, IUGR)
- ☐ Previous cesarean birth How many? _____
- ☐ Other_____
- ☐ None

TOXICOLOGY– were toxicology tests administered to mother and/or the newborn?
☐ No ☐ Yes If yes, Results:

PRINICPAL SOURCE OF PAYMENT for this delivery
- ☐ Private insurance
- ☐ Self-pay
- ☐ Champus/Tricare
- ☐ Other _____
- ☐ Medicaid
- ☐ Indian health service
- ☐ Other government

Mother's Medical II - Delivery

Infections present / treated
- ☐ Chlamydia
- ☐ Genital herpes
- ☐ Gonorrhea
- ☐ GBS
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ HIV positive
- ☐ Syphilis
- ☐ Other _____
- ☐ None

Prenatal OB procedures
- ☐ Cerclage
- ☐ Tocolysis
- ☐ Version
- ☐ None

Mother transferred prior to delivery? ☐ Yes ☐ No
Facility she was transferred from

Onset of labor
- ☐ PROM (> 12 hours)
- ☐ Precipitous labor (< 3 hours)
- ☐ Prolonged labor (>20 hours)
- ☐ None

Characteristics of labor
- ☐ Induction of labor
- ☐ Augmentation of labor
- ☐ Non-vertex presentation
- ☐ Steroids for fetal lung maturation prior to birth
- ☐ Antibiotics received during labor
- ☐ Chorioamnionitis diagnosed during labor
- ☐ Maternal temp >38 C
- ☐ Meconium staining (moderate - heavy)
- ☐ Fetal intolerance of labor requiring one corrective action: In-utero resuscitative measures, further fetal assessment, or operative birth
- ☐ Epidural or spinal anesthesia
- ☐ Other: _____
- ☐ None of the above

DATE OF DELIVERY

TIME of Birth ☐ AM ☐ PM ☐ 24 hr.

Method of birth
- ☐ Forceps attempted ☐ Successful ☐ No
- ☐ Vacuum attempted ☐ Successful ☐ No

Fetal presentation ☐ Cephalic ☐ Breech ☐ Other_____
- ☐ Vaginal/spontaneous
- ☐ Vaginal/vacuum
- ☐ Vaginal / forceps
- ☐ VBAC
- ☐ Cesarean Was trial of labor attempted? ☐ Yes ☐ No

Maternal morbidity
- ☐ Maternal transfusion
- ☐ Cord prolapse
- ☐ Placental abruption
- ☐ Ruptured uterus
- ☐ Admission to ICU
- ☐ None
- ☐ 3rd or 4th deg. perineal laceration
- ☐ Seizure during labor
- ☐ Placenta previa
- ☐ Unplanned hysterectomy
- ☐ Unplanned Operating Rm procedure
- ☐ Other _____

NAMING YOUR BABY AND BIRTH CERTIFICATE INFORMATION

The information provided on this worksheet will be used to create your child's birth certificate.
Please complete this information carefully and completely.

Mother's Information

CURRENT FIRST NAME	CURRENT MIDDLE NAME	CURRENT LAST NAME
NAME BEFORE FIRST MARRIAGE (FIRST)	NAME BEFORE FIRST MARRIAGE (MIDDLE)	NAME BEFORE FIRST MARRIAGE (LAST)
BIRTHPLACE – STATE OR FOREIGN COUNTRY	BIRTHPLACE - CITY	DATE OF BIRTH / /
RESIDENCE ADDRESS (include city and zip code)		
COUNTY OF RESIDENCE	IF NOT WITHIN CITY LIMITS, NAME OF TOWNSHIP	SOCIAL SECURITY NUMBER - -
MAILING ADDRESS		☐ SAME AS RESIDENCE ADDRESS

Baby's Information

You can give your baby any name you choose. Legally, it is permissible to give your child the last name of the mother or father, or any name of your choosing. Names print on birth certificates in all capital letters. Apostrophes and hyphens can be placed between two letters, but not at the beginning or end of a name. No other special characters are permitted.

BABY'S FIRST NAME	BABY'S MIDDLE NAME	BABY'S LAST NAME	
DATE OF BIRTH / /	SEX	☐ SINGLE ☐ TWIN ☐TRIPLET _____	IF NOT A SINGLE, BIRTH ORDER

Do you wish to apply for a free **Social Security Number for your baby** now? Checking the box authorizes the State to give the Social Security Administration information from this form which is needed to assign a number. ☐ **Yes** ☐ **No**

BIRTH ATTENDANT	PLACE OF THIS BIRTH ☐ Hospital ☐ Mother's Residence ☐ Other (specify):

Parents' Information

Are you legally married now, or were you divorced or widowed during this pregnancy? ☐ **Yes** ☐ **No**

In the state of Minnesota, if you were married at any time during the pregnancy, even if you are divorced or widowed now, your husband is legally the father of your baby and his name and place of birth will appear on the birth certificate.

If you are unmarried, no information will print on the birth certificate unless you and the father choose to complete a *Voluntary Recognition of Parentage* form to establish paternity.

If you are married and your husband is not the father of your baby, do you wish to complete a *Husband's Non-Paternity Statement* and a *Voluntary Recognition of Parentage*?
☐ **Yes** ☐ **No** Both forms are required to remove the husband's name and add the father.

If you are single and would like the father's name on this birth record, you and the father can sign a *Voluntary Recognition of Parentage* (ROP) form. This means the father accepts legal responsibility for this child.
☐ **Yes** we will sign a Recognition of Parentage (ROP) form
☐ **No** the Recognition of Parentage will not be signed at this time. I understand no father's information will appear on the birth certificate.

If you are single, your baby's birth record is considered confidential unless you request a public record. Confidential birth records may be purchased by a parent or guardian of the child, the child at age 16, or disclosed according to court order, but they are not available for grandparents, siblings or spouses.
☐ **Yes** change the birth record to a public record
☐ **No** leave the birth record as a confidential record

Father's Information

FIRST NAME	MIDDLE NAME	LAST NAME SUFFIX
DATE OF BIRTH / /	BIRTHPLACE – STATE OR FOREIGN COUNTRY	BIRTHPLACE - CITY
SOCIAL SECURITY NUMBER - -	MAILING ADDRESS	☐ SAME AS MOTHER'S ADDRESS

ADDITIONAL INFORMATION

For birth record research. This information does not print on the birth certificate.

DID YOU PARTICIPATE IN WIC NUTRITIONAL PROGRAM DURING THIS PREGNANCY? ☐ **Yes** ☐ **No** If *yes*, what month of pregnancy did WIC begin? (1st, 2nd, 3rd, etc.)	SMOKING – Did you smoke cigarettes 3 months before or during this pregnancy? ☐ **Yes** ☐ **No** If yes, indicate number of ☐ cigarettes or ☐ packs per day _____ 3 months before _____ First trimester _____ Second trimester _____ Third trimester

BOTH PARENTS' DEMOGRAPHICS – EDUCATION

Check the box that best describes your highest level of school completed at the time of this baby's birth

MOTHER	FATHER	
☐	☐	8th grade or less
☐	☐	9th – 12th grade, no diploma
☐	☐	High school graduate or GED completed
☐	☐	Some college credit, but no degree
☐	☐	Associate degree (e.g. AA, AS)
☐	☐	Bachelor's degree (e.g. GA, AB, BS)
☐	☐	Master's degree (e.g. MA, MS, MEng, Med, MSW, MBA)
☐	☐	Doctorate (e.g. PhD, EdD) or Professional degree (e.g. MD, DDS, DVM, LLB, JD)

BOTH PARENTS' DEMOGRAPHICS – HISPANIC ORIGIN

Check all that apply

MOTHER	FATHER	
☐	☐	No, not Spanish/Hispanic /Latina/Latino
☐	☐	Yes, Mexican, Mexican American
☐	☐	Yes, Puerto Rican
☐	☐	Yes, Cuban
☐	☐	Yes, other Hispanic (e.g. Salvadoran, Dominican, Colombian) (specify) _____

BOTH PARENTS' DEMOGRAPHICS – RACE/ETHNICITY

Check all that apply

MOTHER	FATHER	
☐	☐	**White**
☐	☐	**Black or African American**
☐	☐	Somali
☐	☐	Liberian
☐	☐	Kenyan
☐	☐	Nigerian
☐	☐	Ethiopian
☐	☐	Ghanaian
☐	☐	Other African (specify) _____
☐	☐	**American Indian or Alaska Native** (specify name of enrolled or principal tribe) _____
☐	☐	**Asian**
☐	☐	Asian Indian
☐	☐	Chinese
☐	☐	Filipino
☐	☐	Japanese
☐	☐	Korean
☐	☐	Cambodian
☐	☐	Laotian
☐	☐	Vietnamese
☐	☐	Other Asian (specify) _____
☐	☐	**Pacific Islander**
☐	☐	Native Hawaiian
☐	☐	Guamanian or Chamorro
☐	☐	Samoan
☐	☐	Other Pacific Islander (specify) _____
☐	☐	**Other Race** (specify) _____